**Form 141 Revised 06/2007** Original ( ) Amended ( ) Reason(s) for Amendment _____
Total Cumulative Lost Work Days Due to this Injury_____

**STATE OF UTAH, LABOR COMMISSION, DIVISION OF INDUSTRIAL ACCIDENTS**
**P. O. Box 146610**
**Salt Lake City, UT 84114-6610**
**(801) 530-6800 Fax (801) 530-6804**

# INITIAL STATEMENT OF INSURANCE CARRIER OR SELF-INSURER WITH RESPECT TO PAYMENT OF BENEFITS

EMPLOYEE _____ DATE CARRIER NOTIFIED OF LOST TIME _____

ADDRESS _____ EMPLOYEE PHONE: _____

_____ SOCIAL SECURITY NUMBER _____

CLAIM NUMBER _____ DATE OF INJURY _____

Claim is for: Injury ( ) EMPLOYER _____

Occupational Disease ( ) ADDRESS _____

CITY, STATE, ZIP _____

## COMPUTATION OF BENEFIT RATE

Basic Rate of Pay (Specify whether per hr/day/week/month) _____ $_____

Basic Benefit Rate (2/3 of Gross Avg. Weekly Wage not to exceed Maximum) = $_____

$5.00 dependency allowance for spouse _____ and _____ dependent children $_____

Amount of weekly benefit (Basic + Dep. Allowance) = $_____

The Maximum =100% State Average Weekly Wage: Dependents' benefits of $5.00 for spouse and $5.00 for each dependent minor child under 18 (up to 4) is added to reach maximum, but at no time can the weekly benefits exceed the maximum, or be less than the minimum of $45.00 per week. The maximum up to July 1, 2003 to June 30, 2004 -- $579.00 per week; July 1, 2004 to June 30, 2005 -- $589.00 per week; July 1, 2005 to June 30, 2006 -- $609.00 per week; July 1, 2006 to June 30, 2007 -- **$631.00. July 1, 2007 to June 30, 2008 -- $665.00.** The first 3 days are not compensable unless 15 days or more are missed.

First check for _____ weeks _____ days from _____ to _____ in the amount of $_____ was mailed on _____.

Insurance Carrier _____ Phone _____

Insurance Adjuster _____ Insurance Adjuster's Signature _____
(Type or Print)

Insurance Adjuster's Address _____
(Street / PO Box) (Phone Number) (City, State, Zip)

"Statement of Insurance Carrier or Self-Insured with Respect to Payment of Benefits – Form 141" - This form is used for reporting the initial benefits paid to an injured employee. This form must be filed with or mailed to the Labor Commission on the same date the first payment of compensation is mailed to the employee. A copy of this form must accompany the first payment.

NOTICE TO EMPLOYEE Travel Reimbursement for Medical Care: You may be eligible for reimbursement for travel to and from medical care which has been authorized by the insurance carrier (per rule R612-2-20). You will need to contact your insurance adjuster.

"For your protection Utah law requires notification that any workers' compensation fraudulent claim or disability compensation or medical benefits is a crime and may be subject to fines and confinement in state prison."

*Street Address: Heber Wells Bldg, 160 East 300 South, 3rd Floor, Salt Lake City, UT*